Application for Residential Treatment Center (RTC) Placement

DIRECTIONS: The referring physician must complete this application. In addition to this completed application, submission of any available/applicable supporting documentation is recommended (see page 3) with the application. ValueOptions-TRICARE will process the request, once adequate information is received.

GENERAL INFORMATION

DATE OF REQUEST: _____

PATIENT'S NAME: _____ **PATIENT'S DOB**: _____

PATIENT'S ADDRESS: _____

CUSTODIAL GUARDIAN'S NAME / ADDRESS / WORK AND HOME TELEPHONE NUMBER:

_____

_____

_____

SPONSOR NAME: _____ **SPONSOR SSN #:** _____-_____-_____

RTC FACILITY REQUESTED: _____

CURRENT TREATMENT

DIAGNOSIS:

AXIS I: _____ _____ _____ AXIS II: _____ AXIS III: _____

DESCRIBE PATIENT'S CURRENT CONDITION, INCLUDING MENTAL STATUS AND BEHAVIORAL SYMPTOMS, FOR WHICH RESIDENTIAL TREATMENT MIGHT BE NEEDED:

_____

_____

_____

_____

DESCRIBE PATIENT'S CURRENT TREATMENT PROGRAM (include date of admission/treatment modalities/ frequency/etc):

_____

_____

_____

DESCRIBE PATIENT'S RESPONSE TO CURRENT TREATMENT PROGRAM, INDICATING WHAT ASPECTS HAVE BEEN EFFECTIVE AND WHAT ASPECTS HAVE BEEN INEFFECTIVE:

_____

_____

_____

_____

CURRENT MEDICATIONS: (include all medications)

Medication	Dosage	Frequency	Start Date	End Date
_____	_____	_____	____ - ____ - ____	____ - ____ - ____
_____	_____	_____	____ - ____ - ____	____ - ____ - ____
_____	_____	_____	____ - ____ - ____	____ - ____ - ____
_____	_____	_____	____ - ____ - ____	____ - ____ - ____
_____	_____	_____	____ - ____ - ____	____ - ____ - ____

DESCRIBE ANY COMMUNITY OR MILITARY AGENCIES INVOLVED IN WORKING WITH THIS PATIENT OR WITH THE FAMILY. INCLUDE COURT/LEGAL HISTORY, SOCIAL SERVICES, FAMILY ADVOCACY, SCHOOL SYSTEM, ETC.:

PAST TREATMENT HISTORY

PROVIDE A CHRONOLOGICAL DETAIL OF PAST TREATMENT EFFORTS AND A SUMMARY OF THE PATIENT'S PRIOR TREATMENT HISTORY (include names of past providers and facilities):

PROPOSED TREATMENT PLAN

WHAT ARE THE GOALS OF RESIDENTIAL TREATMENT CENTER PLACEMENT? (Be specific)

_____

_____

WHAT IS THE ESTIMATED LENGTH OF STAY IN RESIDENTIAL TREATMENT?

_____

DESCRIBE THE SPECIFIC DISCHARGE PLANS AND AFTERCARE NEEDS FOR THIS PATIENT. DETAIL ISSUES REGARDING FAMILY SUPPORT, EDUCATIONAL/VOCATIONAL PLACEMENT AND CONTINUED TREATMENT NEEDS:

_____

_____

_____

_____

RECOMMENDED DOCUMENTATION

To assist in determining medical necessity for residential treatment placement, please include the following clinical documentation as available/applicable:

- ☐ Family/Social History
- ☐ Psychiatric/Clinical Evaluation (including presenting problem, diagnosis, treatment needs, prognosis)
- ☐ Current Psychological Evaluation (including testing)
- ☐ Educational Assessment with Levels of Academic Achievement
- ☐ Physical and Neurological Examination Results
- ☐ Discharge Summaries from Previous Inpatient and Outpatient Treatment

PHYSICIAN INFORMATION/CERTIFICATION

I certify that I am the person rendering this patient's face-to-face clinical services and the above statements are true and I have obtained appropriate signed release for all information provided to ValueOptions-TRICARE.

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE #: (____)_____ **FAX: (____)_____**

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

SUBMISSION INFORMATION - SEND APPLICATION AND ALL SUPPORTING DOCUMENTATION TO:

ValueOptions-TRICARE
P.O. Box 551188
Jacksonville, Florida 32255-1188
ATT: Utilization Management Department
FAX: 904-363-0233
celina.sample@jax.valueoptions.com